

Patient Name \_\_\_\_\_  
 Patient Account No. \_\_\_\_\_

Medical Alert \_\_\_\_\_

*Welcome! So that we may provide you with the best possible care  
 please complete both sides of this medical/dental history form.  
 All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

- |   |     |    |
|---|-----|----|
| Hot or cold?  | Yes | No |
| Sweets?   | Yes | No |
| Biting or Chewing?  | Yes | No |
| Have you noticed any mouth odors or bad tastes?                       | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |
| Do your gums bleed or hurt?   | Yes | No |
| Have your parents experienced gum disease or tooth loss?              | Yes | No |
| Have you noticed any loose teeth or change in your bite?              | Yes | No |
| Does food tend to become caught in between your teeth?                | Yes | No |

If yes, where? \_\_\_\_\_

**Do you:**

- |   |     |    |
|---|-----|----|
| Clench or grind your teeth while awake or asleep?                               | Yes | No |
| Bite your lips or cheeks regularly?   | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep?  | Yes | No |
| Have tired jaws, especially in the morning?                                     | Yes | No |
| Snore or have any other sleeping disorders?                                     | Yes | No |
| Smoke/chew tobacco or use other tobacco products?                               | Yes | No |

**Have you ever had:**

- |   |     |    |
|---|-----|----|
| Orthodontic treatment?                  | Yes | No |
| Oral Surgery?                           | Yes | No |
| Periodontal treatment?                  | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard?            | Yes | No |
| A serious injury to the mouth or head?  | Yes | No |
- If so, please describe, including cause \_\_\_\_\_

**Have you experienced:**

- |  |     |    |
|--|-----|----|
| Clicking or popping of the jaw?                    | Yes | No |
| Pain? (joint, ear, side of face)                   | Yes | No |
| Difficulty in opening or closing the mouth?        | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches?            | Yes | No |
| Sore muscles (neck, shoulders)?                    | Yes | No |

**Are you satisfied with your teeth's appearance?**

- |   |     |    |
|---|-----|----|
| Would you like to keep all of your teeth all of your life?                              | Yes | No |
| Do you feel nervous about having dental treatment? If so, what is your biggest concern? | Yes | No |
| Have you ever had an upsetting dental experience? If yes, please describe _____         | Yes | No |

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe \_\_\_\_\_

(Please complete other side)